Mansfield Middle School Athletics Program: SPORTS PERMISSION FORM

STUDENT NAME: _____ AGE: _____ GRADE:_____

DOB: _____ /_____/ _____ I give permission for _____ to participate in organized middle school athletics, realizing that such activity involves the potential for injury, which is inherent in all sports. I acknowledge that even with the best coaching, use of appropriate equipment and strict observance of rules, injuries are a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge that I have read and understand this warning, and agree not to hold the school district or its personnel responsible for any injury that may occur during practices, scrimmages, games, or transportation to athletic events.

Circle all <u>possible sports</u> for your child: Soccer Cross Country Basketball Baseball Softball Track and Field

_____ _____

Parent/Guardian Signature Date

<u>STUDENT EMERGENCY INFORMATION</u> <u>(*) The best number to reach you during after school sports)</u>

STUDENT ADDRESS: _____

Street Town

<u>PARENT/GUARDIAN INFORMATION</u>

Parent/Guardian Name: _____ Home Phone: _____
Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

Parent/Guardian Name: _____ Home Phone: _____
Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

<u>EMERGENCY CONTACTS</u>

List two (2) neighbors or relatives who will assume temporary care of your child if you cannot be reached. (They must be at least 18 years old.)

1. Name: _____ Phone: (_____)_____

2. Name: _____ Phone: (_____)_____

<u>AUTHORIZATION FOR FIRST AID AND MEDICAL TREATMENT</u>

In case of accident, illness or injury, I grant permission for school personnel to administer first aid and/or secure medical treatment for my child. In the event of an emergency, your child will be taken to the nearest medical facility.

Parent/Guardian Signature: _____ Date: _____

Important Note to Parents/Guardians:
The MMS Health Room closes daily at 3:15. There is **<u>no nursing coverage</u>** for after school sports or activities. If your child has a known medical need (such as; asthma, severe allergy, seizures, diabetes…) and may need medication or medical supervision during after school sports, a parent/guardian must contact the school nurse in order to make the necessary plans or arrangements. The appropriate care and guidelines will be delegated to <u>coaches</u>. MMS does not provide nursing coverage beyond the school day. These arrangements will need to be updated for each sport your child participates in each quarter.

If your child has an authorization for medication on file in the health room, an <u>additional</u> inhaler or EpiPen must be provided for use during interscholastic sports.

This information will be shared with your child's coaches.

MANSFIELD MIDDLE SCHOOL
SPORTS PARTICIPATION HEALTH RECORD

This evaluation is to determine readiness for sports participation only

STUDENT NAME _____ **Age** _____ **Sex** _____ **Grade** _____ **Phone** _____

Address _____

Circle all possible sports for your child: **Soccer** **Cross Country** **Basketball** **Baseball** **Softball** **Track and Field**

MEDICAL HISTORY

(To be completed by student and parent or guardian)

Do you have any allergies? (food, drugs, insect stings, etc.)
YES ____ NO ____ List: _____

Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally)
YES ____ NO ____ List: _____

Are you presently being treated for any condition by a physician or other health care professional?
YES ____ NO ____ Explain: _____

Have you ever been advised by a doctor not to participate in any sport?
YES ____ NO ____ Explain: _____

Do you have any chronic conditions, disorders or diseases?
YES ____ NO ____ if yes, check those applicable:

Asthma ____ Bleeding Disorders ____ Diabetes ____
Epilepsy (seizures) ____ Hepatitis (liver disease) ____ Sickle Cell Anemia ____
Hypertension (high blood pressure) ____ Mononucleosis ____ year _____ Kawasaki's Disease ____
Handicap (describe) _____ Other _____

Please check where applicable if you have or have had any of the following:

YES	YEAR		YES	YEAR
____	____	Head injury, concussion, or been unconscious If yes, how many times _____	____	____
____	____	Headaches more than once a week	____	____
____	____	Lack of feeling or numbness in any part of the body	____	____
____	____	Heat exhaustion or heat stroke	____	____
____	____	Difficulty running ½ mile without stopping	____	____
____	____	Chest pain, dizziness or passing out during exercise	____	____
____	____	Coughing, wheezing or gasping for breath with exercise or cold weather	____	____
____	____	Smoke cigarettes or chew tobacco	____	____
____	____	Heart problem, murmur or arrhythmia	____	____
____	____	Family member with a heart attack under age 50	____	____
____	____	Loss or gain of more than 10 lbs. in last year	____	____
____	____	Special diet for medical reasons	____	____
		For female participants:		
____	____	Absent or irregular monthly periods	____	____
____	____	Disabling cramps with your menstrual periods	____	____
____	____	Eye injury or retinal detachment	____	____
____	____	Blurred vision or vision in one eye only	____	____
____	____	Wear glasses or contact lenses	____	____
____	____	Hearing loss or impairment in one or both ears	____	____
____	____	Tubes in ears or a perforated eardrum	____	____
____	____	False teeth, caps or braces	____	____
____	____	Nose bleeds for no reason	____	____
____	____	Bruising easily or taking a long time to stop bleeding when cut	____	____
____	____	Diarrhea more than once a week	____	____
____	____	Black or bloody bowel movements (stools)	____	____
____	____	Kidney disease or dark, brown or bloody urine	____	____
____	____	Less than 2 kidneys or, in males, 2 testicles	____	____
____	____	Lump(s) in armpit or groin	____	____
____	____	Rash or skin problem	____	____
____	____	Neck or spine or low back injury or pain	____	____

LIST ANY HOSPITALIZATIONS:

REASON	YEAR	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any injury (nerve, bone, muscle or joint) that you have had which did not allow you to participate in regular activity for a week or more.

INJURED AREA (Knee, hamstring, neck, etc)	**SIDE (R, L)**	**YEAR**	**TYPE** (Fracture, sprain, pinched nerve, swelling)	**RESOLVED Y/N**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

STUDENT AND PARENT OR GUARDIAN: We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

_____ _____ _____ _____
Student Signature Date Parent or Guardian Signature Date

This information will be shared with your child's coaches.

PHYSICAL EXAMINATION

Required within 24 months of Sports Participation

(To be completed by MD, APRN, or PA)

_____ _____/_____/_____ **has had a history and physical exam on** ____/____/____

Student's Name **Birth Date**

	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular	**Arrhythmia**	
	Murmur	
Abdomen		
Spine		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage)	**1 2 3 4 5**	

HEIGHT _____ _____ **WEIGHT** _____

BLOOD PRESSURE _____

HCT/HGB_____

PULSE _____

URINALYSIS _____ **protein** _____ **blood** _____ **glucose** _____

VISUAL ACUITY: **right** _____ **left** _____

Corrected to **right** _____ **left** _____

HEARING _____

LAST TETANUS BOOSTER _____

LAST MEASLES (MMR) BOOSTER _____

OTHER IMMUNIZATIONS _____

BODY FAT (optional) _____

CHOLESTEROL (optional) _____

SUMMARY:_____

_____

_____

_____

ORTHOPEDIC EXAM

MUSCULO-SKELETAL EVALUATION to include range of motion, strength, flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

RECOMMENDATIONS

Weight Loss / Gain _____

Strengthening _____

Stretching _____

Conditioning (Endurance) _____

Medications _____

Special Equipment _____

Bracing / Taping _____

I certify that on this date, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except:

_____

_____

_____

_____ _____ _____ _____

Provider Signature **Date** **Telephone** **Printed Name or Stamp**

This information will be shared with your child's coaches.